

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2101  
CERTIFICATE OF DEATH

02094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent County</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent County</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown,</b>			c. LENGTH OF STAY IN 1b <b>20 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Rollison</b> Middle <b>Baxter</b> Last <b>Baxter</b>			4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1886</b>		9. AGE (In years last birthday) <b>73 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Oil Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Petroleum</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>America U. S. A</b>		13. FATHER'S NAME <b>Samuel W. Baxter</b>			
14. MOTHER'S MAIDEN NAME <b>Eudora Rollison</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-03-9638</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic obstruction</b> DUE TO (c) <b>?</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute enteritis, parotitis, partial intestinal obstruction (polyp)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>?</b>	
20f. (City or town) <b>?</b>		20g. (County) <b>?</b>		20h. (State) <b>?</b>	
21. I certify that I attended the deceased from <b>January 2, 1960</b> , to <b>February 1, 1960</b> , that I last saw the deceased alive on <b>February 1, 1960</b> , and that death occurred at <b>7:07 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b> DATE SIGNED <b>2/3/60</b>					
ACTUAL SIGNATURE <b>A. C. Dick</b> M.D.					
PHYSICIAN'S NAME (Type) <b>A. C. Dick, M. D.</b> <b>Chestertown, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>February 3, 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Chestertown, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Wells</b>		ADDRESS <b>Chestertown, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Caribou S. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

CERTIFICATE OF DEATH

10000

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2102

CERTIFICATE OF DEATH

02095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b> d. STREET ADDRESS <b>316 Cannon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HERMAN</b> First <b>JAMES</b> Middle <b>BENTON</b> Last 4. DATE OF DEATH <b>Feb</b> Month <b>14</b> Day <b>19</b> Year <b>60</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>Cplored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 21, 1883</b> 9. AGE (In years and birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laboring</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>various</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Benton</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>(sister) Effie Wagstaff, Philadelphia, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congest ive Heart Failure</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>many years</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/2/60</b> , 19 <b>60</b> , to <b>2/14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/14/60</b> , 19 <b>60</b> , and that death occurred at <b>2:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown Md.</b> DATE SIGNED <b>Feb 14, 1960</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. <b>Chestertown Md.</b> <b>Feb 14, 1960</b>					
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Senneth Walby</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

PLoS ONE

5

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2108

CERTIFICATE OF DEATH

Items 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

02096

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Worton</b>		c. LENGTH OF STAY IN 1b <b>adult life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julius Chambers</b>		4. DATE OF DEATH <b>2/3/60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Chambers</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>171-10-9157</b>	
17. INFORMANT <b>Mrs. Anna Hynson</b>		Address <b>RFD Worton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO <b>Hypertension</b> 444X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1959</b> to <b>Feb. 3, 1960</b> , that (I) (we) lost the deceased alive on <b>1/25</b> 19 <b>60</b> and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Kester</b>		22b. DATE SIGNED <b>2/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eugene Kester</b>		22d. ADDRESS <b>Rock Hall, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/6/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bigwoods Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>near Worton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walby</b>		25a. REC'D BY REGISTRAR <b>Charing L. Kneass</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charing L. Kneass</b>	

02000

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1910

1

1

DEATH CERTIFICATE

1910

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2109

## CERTIFICATE OF DEATH

Reg. Dist. No.

02097

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b>		c. LENGTH OF STAY IN 1b <b>Millington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EVELYN</b> Middle <b>COCHRAN</b> Last <b>COCHRAN</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February, 17, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>60</b> Min.	IF UNDER 24 HRS. Hours <b>60</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Alvin Cochran</b>		14. MOTHER'S MAIDEN NAME <b>Emma Millington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss, Martha Hazell,</b>		Address <b>Millington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) <b>Senile debility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>5</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Millington, MD</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 8</b> , 19 <b>60</b> , to <b>Feb. 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 1</b> , 19 <b>60</b> , and that death occurred at <b>10:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>GEZA KORALEWSKI</b>		M.D. <b>MILLINGTON, MD</b>	
PHYSICIAN'S NAME (Type) <b>GEZA KORALEWSKI</b>		DATE SIGNED <b>2-2-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Millington Cemetery</b>
22d. LOCATION (City, town, or county) <b>Millington, Kent Co. Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward T. Holloway</b>		ADDRESS <b>Millington, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	

# CERTIFICATE OF DEATH

1903

MARYLAND STATE DEPARTMENT OF HEALTH

1903

<p>1. NAME OF DECEASED                  WILLIAMSON</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  45</p>	
<p>4. DATE OF DEATH                  1903</p>		<p>5. PLACE OF DEATH                  Baltimore</p>		<p>6. CAUSE OF DEATH                  Heart Disease</p>	
<p>7. OCCUPATION                  Merchant</p>		<p>8. RESIDENCE                  1234 Main St., Baltimore</p>		<p>9. MARITAL STATUS                  Married</p>	
<p>10. NAME OF WIFE                  Mary Williamson</p>		<p>11. NAME OF CHILDREN                  John, William, Mary</p>		<p>12. NAME OF NEXT OF KIN                  John Williamson</p>	
<p>13. NAME OF PHYSICIAN                  Dr. J. H. Smith</p>		<p>14. NAME OF BURIAL PLACE                  St. Mary's Cemetery</p>		<p>15. NAME OF FUNERAL HOME                  J. H. Smith &amp; Co.</p>	
<p>16. NAME OF CORONER                  J. H. Smith</p>		<p>17. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>18. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>19. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>20. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>21. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>22. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>23. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>24. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>25. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>26. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>27. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>28. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>29. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>30. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>31. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>32. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>33. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>34. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>35. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>36. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>37. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>38. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>39. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>40. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>41. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>42. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>43. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>44. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>45. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>46. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>47. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>48. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>49. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>50. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>51. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>52. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>53. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>54. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>55. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>56. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>57. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>58. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>59. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>60. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>61. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>62. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>63. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>64. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>65. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>66. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>67. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>68. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>69. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>70. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>71. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>72. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>73. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>74. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>75. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>76. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>77. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>78. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>79. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>80. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>81. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>82. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>83. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>84. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>85. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>86. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>87. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>88. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>89. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>90. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>91. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>92. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>93. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>94. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>95. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>96. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>97. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>98. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>99. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	
<p>100. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>101. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>		<p>102. NAME OF JURY                  J. H. Smith, J. H. Smith, J. H. Smith</p>	

RECEIVED  
 1903

2103

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kermit</b> Middle <b>Roosevelt</b> Last <b>Hynson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1910</b>
9. AGE (In years lost birthday) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Worton, Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Hynson</b>		14. MOTHER'S MAIDEN NAME <b>Ida</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-7852</b>	
17. INFORMANT <b>Hospital Records, Chestertown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>541.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bleeding duodenal ulcer</b> DUE TO (c) <b>Chronic duodenal ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1958</b> , to <b>February 4 1960</b> , that I last saw the deceased alive on <b>February 3, 1960</b> , and that death occurred at <b>1:00a.m.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.C. Dick</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>A.C. Dick, M.D.</b>		DATE SIGNED <b>2-4-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Worton Point Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>rural Worton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Denneth W. Day</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2110

CERTIFICATE OF DEATH

Reg. Dist. No.

02099

1. PLACE OF DEATH o. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADAM NATHAN KELLEY</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 1 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 16 - 1880</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>DECATOR KELLEY</b>				14. MOTHER'S MAIDEN NAME <b>EMMA ROBERTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-26-3942</b>		17. INFORMANT <b>Mrs. Emily Finch - Rock Hall</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sanility</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> , to <b>Jan. 31, 1960</b> , that I last saw the deceased alive on <b>Jan. 31, 1960</b> , and that death occurred at <b>12:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Kester</b>				ADDRESS (Street, city or town, state) <b>Rock Hall</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>E. Kester</b>				<b>Rock Hall</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 3</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Havel</b>				ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

# 2110 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

031953

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX MALE		RACE WHITE	
DATE OF BIRTH JAN 1 1900		DATE OF DEATH JAN 1 1900	
TIME OF DEATH 10:00 AM		TIME OF BIRTH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		CAUSE OF BIRTH NORMAL	
PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX MALE		RACE WHITE	
DATE OF BIRTH JAN 1 1900		DATE OF DEATH JAN 1 1900	
TIME OF DEATH 10:00 AM		TIME OF BIRTH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		CAUSE OF BIRTH NORMAL	

RECEIVED AT BALTIMORE  
 JAN 1 1900  
 DEPARTMENT OF HEALTH

2104

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesutown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Millington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marlin Miles Massey</u>		4. DATE OF DEATH Month Day Year <u>2 13 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1959</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>2 9</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rowling Massey, Jr</u>		14. MOTHER'S MAIDEN NAME <u>Maryland Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Maryland Massey, Millington, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown, but probably focal bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infant was apparently well at 9:00 am 2-13-60</u> DUE TO <u>+ was found dead at 11 am</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-4</u> , 19 <u>59</u> , to <u>2-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>60</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Kent Wain</u>		ADDRESS (Street, city or town, state) <u>Chesutown, Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>		DATE SIGNED <u>2-13-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM. MILLINGTON, MD.</u>	22d. LOCATION (City, town, or county) (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward S. Fellows, Millington, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

2072221XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02101

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Kent</u> <span style="float: right;">2111</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS  		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Emily Virginia Price</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>February 19 19 60</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 11-1902</u>	
<b>9. AGE</b> (In years last birthday) <u>57</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>John Newsome</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>  		<b>17. INFORMANT</b> <u>Raymond Price--Rock Hall, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>970.2</u> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="width: 60%;"> <u>Unknown but probable barbiturate poisoning a few (Toxicology report not yet back from Medical Examiners laboratory)</u>  <b>DUE TO (b)</b>  <u>Found dead about 11:30 P.M. 2/19/60. There was a bottle containing Nembutal nearby. The family believes she took a large but unknown number of them. Autopsy findings at present show no detectable cause of death.</u> </div> <div style="width: 10%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>hours</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>she took a large but unknown number of them. Autopsy findings at present show no detectable cause of death.</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Rock Hall</u>		<b>20f. (City or town) (County) (State)</b> <u>Kent Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Robert W. Farr</u>				<b>DATE SIGNED</b> <u>2/22/60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Robert W. Farr, M. D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>FEB 22</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Wesley Chapel</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Rock Hall, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar L. Lane</u>				<b>ADDRESS</b> <u>Church Hill Ind.</u>		<b>24a. RECEIVED BY REGISTRAR</b> <u>FEB 23 60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Thomas</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2112 CERTIFICATE OF DEATH

02102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>dent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>dent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Elizabeth</u> Middle <u>Price</u> Last		4. DATE OF DEATH <u>Feb</u> Month <u>4</u> Day <u>1960</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13-1959</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>V</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Price</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas Price</u>		Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10<sup>th</sup></u> , 19 <u>59</u> , to <u>Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 10<sup>th</sup></u> , 19 <u>59</u> , and that death occurred at <u>10<sup>th</sup></u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Batewood</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, MD</u> DATE SIGNED <u>2/5/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thura</u>	

2072244XV4

CERTIFICATE OF DEATH

2112

NAME OF DECEASED		DATE OF BIRTH	
MURRAY		1912	
PLACE OF BIRTH		DATE OF DEATH	
BALTIMORE, MARYLAND		1912	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		PLACE OF DEATH	
NATURAL		HOME	
TIME OF DEATH		HOURS	
10:00 AM		10	
DAY OF DEATH		MONTH	
JANUARY		JANUARY	
YEAR OF DEATH		YEAR	
1912		1912	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
DR. J. H. BROWN		J. H. BROWN	
ADDRESS OF PHYSICIAN		ADDRESS OF FUNERAL HOME	
1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
NAME OF REGISTRAR		NAME OF WITNESS	
J. H. BROWN		J. H. BROWN	
ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	

2105

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anns.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>JANE</u> Last <u>Simpers</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1876</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Townsend</u>		14. MOTHER'S MAIDEN NAME <u>EUGENIA Hobbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Hospital Records, Chestertown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Myocardial infarct (old)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 years</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paternal cataracts; hyperuricemia arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-30</u> , 19 <u>59</u> , to <u>2-26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>60</u> , and that death occurred at <u>8:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		DATE SIGNED <u>2-26-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thum</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02104

2113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>E.</b> Last <b>Starr</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9.</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1887</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas C. Roe</b>				14. MOTHER'S MAIDEN NAME <b>Annie Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William L. Starr</b>		Address <b>Galena Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Pulmonary embolism -2 weeks ago. CVA due to thrombosis 2 years ago.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 59</b> , 19, to <b>9 Feb 60</b> , 19, that I last saw the deceased alive on <b>9 Feb 60</b> , 19, and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11 Feb 60</b>							
ACTUAL SIGNATURE <b>Wallace G. Obenshain M.D.</b>		PHYSICIAN'S NAME (Type) <b>Wallace G. Obenshain, M.D.</b> <b>Cecilton, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		22b. DATE THEREOF <b>Feb. 12, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galena Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Miller</b> ADDRESS <b>Millington Md.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>	



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STATE OF DEATH

1114



2106

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>one-half hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>				d. STREET ADDRESS <b>(none)</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Howard</b> Middle <b>Metcalf</b> Last <b>Weller</b>		4. DATE OF DEATH		Month <b>2</b> Day <b>19</b> Year <b>19 60</b>	
S. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/16</b>	
				9. AGE (In years lost birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. of Amer.</b>	
13. FATHER'S NAME <b>Jacob Weller</b>				14. MOTHER'S MAIDEN NAME <b>Addie Wooleyhand</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-36-1314</b>		INFORMANT Address <b>Mrs. Esther S. Weller, Marydel, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Hemorrhage</b> DUE TO <b>Hypertension</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>2 hours</b> <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/19</b> , 19 <b>60</b> , to <b>2/19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/19</b> , 19 <b>60</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Thomas J. Solon</b>				M.D. _____			
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>				<b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Fellows, Millington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Queen Anne's

18.

Rest

One-half m. West of town

Queen Anne's (none)

Howard

White

Barren

Island

Mr. Esther S. Keller

*What is the value of the land?*

*It is worth \$100.00*

*100.00*

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (rural)</b>		c. LENGTH OF STAY IN 1b <b>8 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. D. 2</b>			d. STREET ADDRESS <b>R. D. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Wilford O. Wolfe</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>18</b> Year <b>19 60</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 6 1911</b>		9. AGE (In years last birthday) <b>48</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Kingwood W..Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Goldey Amanda Wolfe</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W. 11</b>		
16. SOCIAL SECURITY NO. <b>235-20-8385</b>			17. INFORMANT <b>Eva Bircher Box 445 Chestertown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot gun wound - chest</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>instantaneously</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>2/18 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Chestertown</b>		20g. (County) <b>Kent</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Robert W. Farr</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>2/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kingwood Cemetery</b>
22d. LOCATION (City, town, or county) <b>Kingwood, Preston Co. W.Va.</b>			22e. (State) <b>W.Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams Chestertown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>FEB 23 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02107

Chesapeake (1011)

Chesapeake (1011)

Inspected  
and  
signed

See also record - Chesapeake

See also record - Chesapeake

Chesapeake (1011)

Chesapeake (1011)

Chesapeake (1011)

2/1/40

Chesapeake (1011)

Chesapeake (1011)

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G256 2-23-60 et  
2107 CERTIFICATE OF DEATH

Reg. Dist. No. 02108

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN lb <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>(N)</b> Last <b>Yocum</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1892</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>			
13. FATHER'S NAME <b>Leonard Yocum</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Staunago</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>178-18-1467</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma, Pulmonary fibrosis, chronic congestive failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 13</b> , 19 <b>60</b> , to <b>Feb 14</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Feb 14</b> , 19 <b>60</b> , and that death occurred at <b>9:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 N. Queen Street</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Harry Paul Ross</b>				M.D. <b>203 N. Queen Street</b>			
PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS</b>				City or town, state <b>Chestertown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 18</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				ADDRESS <b>Church Hill, Ind.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

25. 26. 27.

1991